John Goodman, Special Adviser for Defense Conversion and Technology
Sheila Cheston, Deputy General Counsel of the Air Force
Dr. Larry Caviaiola, Deputy Under Secretary/Acquisition Operations
Audrey Sheppard, Chief of Protocol
Steven Preston, Deputy General Counsel
Sheila Helm, Special Assistant to the Secretary/Personnel
Dr. Kenneth Flamm, Principal Deputy Assistant Secretary for Acquisition (Dual Use Technology and International Programs)
Joseph Berger, Director, Peacekeeping/Peace Enforcement/Office of the Assistant Secretary for Policy (Democracy and Peacekeeping)
Robert Bayer, Deputy Assistant Secretary/Economic Reinvestment and Base Realignment and Closure
Carolyn Becraft, Deputy Assistant Secretary/Personnel & Readiness (Personnel Support, Families & Education)
Mary Ellen Harvey, Assistant Deputy Under Secretary/Logistics Systems Development
Roy Willis, Principal Assistant Deputy Under Secretary/Logistics
Amy Hickox, Director of Outreach America/Office of the Assistant Secretary (Reserve Affairs)

Biographies of the nominees were made available by the Office of the Press Secretary.

Remarks and a Question-and-Answer Session With the American Association of Retired Persons in Culver City, California

October 5, 1993

The President. Good morning, ladies and gentlemen. Thank you all for coming today. I want to thank Judy Brown and the other board members of the AARP up here and the AARP nationwide for their wonderful cooperation and work with the First Lady and our health care effort over the last several months.

There is no organization in America that better represents the needs and desires of older Americans than the AARP. I've been working with them for nearly 20 years now, and it won't be long until I'll be old enough to be a member. [*Laughter*] So I have a vested interest in your lobbying on the health care plan.

I want to thank especially Mayor Mike Balkman and the people here in Culver City for their warm welcome to all of us today. I thank the Mayor. I'd also like to say a special word of thanks to your Representative in the United States Congress who's here with me, and a great Congressman, and a great ally in this fight for health care security, Congressman Julian Dixon. Congressman.

There are some people here from Congressman Waxman's district. I told him yesterday that since he had a longtime standing interest in health care I would mention today that the reason he's not here is that he's back in Washington having the next hearing on health care. So he took a redeye back last night to do the work that we have to do.

Ladies and gentlemen, as all of you know by now, we have launched a major national debate on health care, with a proposal designed to achieve a disarmingly simple but exceedingly complicated task: to provide health security for all Americans, health care that can never be taken away, that's always there, for the first time in our history and to do it by trying to fix what is wrong with our system while keeping and indeed enhancing what is right with our system.

The first and foremost thing is we have to have more health care security. There is an article today on the front page of many of the papers of the United States saying that last year there were more Americans living in poverty than at any time since 1962; that 37.4 million Americans have no heath insurance; about 2 million Americans a month lose it, about 100,000 of them permanently because the system we have is coming unraveled. It is the most expensive system in the world and yet the only advanced nation which doesn't provide basic coverage to all Americans.

We have gotten 700,000 letters to date, and

we're getting about 10,000 more every week at the White House from people describing their personal experiences and frustrations in problems with America's health care system, not only American health care consumers from parents with sick children to senior citizens who can't afford their medicine but also from doctors and nurses who can't do what they hired out to do, keep people well and treat them when they're sick, for all the bureaucracy and paperwork that's in our system.

I have personally met many older Americans who are literally choosing every month between buying food and buying medicine. And I know that many of these people are actually, in the end, adding to the cost of the health care system because eventually they wind up having to get expensive hospital care for lack of proper medication in managing whatever health condition they have.

We received a letter and then I had a chance to meet a man named Jim Heffernan from Venice, Florida, who came to the Rose Garden a couple of weeks ago. He volunteers at a local hospice trying to help people understand the tangle of forms they have to fill out just in order to get the health care they're entitled to. And he wrote the following thing to me: "I can recall one patient who was in tears and shaking because the hospital in her hometown had placed the balance of her medical charges in the hands of a collection agency and wrote that she might be sent to jail for failure to pay her hospital bill. This kind of senseless action on an elderly, terminal widow is unforgivable."

Stories like this need to be told over and over again in the halls of the Nation's Capitol until, finally, we get action. Our plan will improve what is great about our health care system: the quality of our doctors and nurses; the depth of our research and our commitment to technological advance. Those things will not be interrupted. We will strengthen them. This plan has a lot of aspects which actually strengthen the quality of the American health care system, strengthen the stream of funds going to medical research to deal with the whole range of problems that now confront us, everything from AIDS to Alzheimer's to various kinds of cancer.

We are committed to keeping what is best about this system. Indeed, more and more doctors and nurses who have had a chance to study this system say that we'll have more quality, because they'll have more time to practice their professions, they'll be able to spend less time filling out forms and hassling insurance companies.

I also want to say one thing—[*applause*]—there's one frustrated doctor starting the applause out there. [*Laughter*] There's also one thing I want to say over and over again to the AARP membership of this Nation, and that is that our plan maintains the Medicare program. It will protect your freedom to choose your doctors.

Let's face it, Medicare is one thing the Government has gotten right, it has worked. And its own administrative costs for the Government are pretty modest. There are a lot of problems with Medicare in terms of how doctors and hospitals and others have to deal with it, in light of the complexities of the health care system as a whole. But I think, on balance, the plan works well.

However, if you don't like some parts of your Medicare program today, I can say this: This plan will increase your options. It will give you a chance to pick from any of the health plans offered where you live, some of which may offer plans that are more comprehensive and less expensive than what you receive today.

Second, this health care security plan will give you the help you deserve in paying for prescription drugs. This plan, for the first time, will make people on Medicare who are not poor enough to be on Medicaid eligible for help with their prescription drugs. It also will cover prescription drug benefits for working families. We believe this is important, and if coupled with a reasonable effort to hold prices down and to stop practices that we have in America today, where some not experimental drugs but well-established drugs made in America still cost 3 times as much in America as they do in Europe—that needs to be changed. If we can change that we can afford this benefit and still do what needs to be done.

The third thing that I want to emphasize is that this plan greatly expands your options for finding long-term care services in the home, in the community, in the hospital, not simply in a nursing home. We're not going to be able to do all of this at once. We have to work in the system and make sure we have the funding before we undertake programs we can't pay for. And so we phase in the long-term care benefit between 1996 and the year 2000, and

we start the drug benefit right away.

But in the end, we have to have a comprehensive set of long-term care services. And again I will say, if we do it right it will save money. It is ridiculous for the only kind of long-term care to be reimbursed by the Government, that which is most expensive and which pushes people toward institutional care at a time when the fastest growing group of Americans are people over 80 and more and more people are more active longer. I think here in California there's probably as much support for an active independent approach to long-term care as anywhere in the United States. And I want you to stay after it, and make sure we maintain the commitment to long-term care and to choice in long-term care.

Let me make one last comment that I think is very important. This program also provides for coverage for early retirees. A lot of AARP members are people between the ages of 55 and 65 who have retired early and who don't have access to adequate health care now. Under our program, those people with incomes will have to pay up to 20 percent of their coverage, just like they would if they were in the workplace and uncovered, but at least they will have access to comprehensive services, with 80 percent contributions by the Federal Government. I hope that you will all support that.

Let me say, finally, that we are interested in passing a program that meets the basic criteria that I laid down in my address to Congress. I have searched this country, and the hundreds of people working with us who searched this country for better ideas: How can we continue to simplify this plan? How can we make it even easier to administer? But we must meet certain basic principles. The first one is security. We owe it to the American people, finally, to say that America will join the ranks of the other advanced nations and give every American health care that's always there, that can't be taken away.

We have to simplify this system in order to pay for it. You live in the only country in the world that's spending at least 10 cents on the dollar—now that's a dime on a $900 billion health care bill—on every dollar, that's $90 billion a year being spent on paperwork that no other country finds it necessary to have: Hospitals hiring clerical workers at 4 times the rate of direct health care providers; doctors seeing their income from the money that comes into the clinic go from 75 percent of what comes in down to 52 percent in 10 years, the rest of it being taken away in a vast wash of paperwork and unnecessary bureaucracy. I tell you we can do better than that. And we have to do it.

We have to maintain quality. I've already addressed that. We have to maintain choice of physicians and other health care providers. I have addressed that. We will have to ask every American to be more responsible. And those that have no health insurance today, who aren't paying anything into the system, but who can afford to pay, should be asked to pay because the rest of you are paying for those.

There are people who say—and I want to emphasize this—people say this will be terrible for small business. Folks, most small business people have health insurance. And I met a small business man yesterday in San Francisco with 12 employees whose premiums went up 40 percent this year, and he had no claims. Now, I'm worried about those small business people. They're going to go broke or have to dump their employees and make the situation worse. Those people are trying to do their part by asking everyone to do something in giving discounts to small businesses with low-wage workers, we stop the sort of irresponsible shifting of costs onto the rest of you. We also stop the practice of people getting health care when it's too late, too expensive, and when things don't work right and shift back to preventive and primary care services so people can stay well, instead of just be cared for when they get sick.

Finally, let me say this: We have to achieve some savings, and that's been one of the most controversial parts of this proposal. People say, "Oh, you can't get any savings out of Medicare and Medicaid." I hope we can talk more about this, but let me just tell you how this program is paid for. Two-thirds of the cost of this program will be paid for by contributions from employers and employees who pay nothing to this system today but still get to use it when they get sick, two-thirds of it. One-sixth of the money will come from a tax on tobacco and from asking big companies that will still have the right to self-insure, because many of them have their costs under control and have adequate benefits, they'll be able to continue to do that, but they will be asked, since their costs will go down, too, to pay a modest fee to pay for medical

research and technology and to keep the public health clinics of this country open to do the work that they will have to do. And then one-sixth of it will come from what we call savings.

But I want you to understand what's happening. Today, Medicaid and Medicare are going up at 3 times the rate of inflation. We propose to let it go up at 2 times the rate of inflation. That is not a Medicare or Medicaid cut. And we have kept private sector increases so that they won't go up as much. So only in Washington do people believe that no one can get by on twice the rate of inflation. So when you hear all this business about cuts, let me caution you that that is not what is going on. We are going to have increases in Medicare and Medicaid, and a reduction in the rate of growth will be more than overtaken by the new investments we're going to make in drugs and long-term care. We think it's a good system. We hope you'll support it.

Let me just acknowledge two other people I just saw in the audience I didn't know were here. First, Congresswoman Lucille Roybal-Allard. Thank you for being here. Are there any other Members of the California Congressional Delegation here? Congressman Martinez, stand up there. It's good to see you. I'm sorry. And I want to thank your insurance commissioner, John Garamendi, for all of the work he did to try to show us what's been done in California that we put into our plan.

Thank you very much.

[*At this point, Ms. Brown thanked the President and introduced Anne Jackson, chair of the health care committee of AARP's national legislative council, who discussed the AARP health care proposal and invited participants to ask questions.*]

Q. [*Inaudible*]

The President. He said much of the program is funded with cuts in Medicare; do I really think it won't affect the recipients? Absolutely.

Let me just tell you. We just adopted a budget in Washington which cuts defense deeply, just as much as we can, and we shouldn't do a dollar more. But we have cut it dramatically. And that's one of the reasons the California unemployment rate is up, right, because defense has been cut since 1987. But there's a limit to how much it can be cut. It's cut, absolutely. It freezes all domestic discretionary spending. That is, if I want to put more money into defense conversion in California, or Head Start, or public health clinics, the Congress and the Members here will tell you, they have to find for the next 5 years a dollar in cuts somewhere else for every dollar we want to spend in some new program.

The only thing we're increasing, except for the cost of living in retirement programs, is Medicare and Medicaid. Everything else is declining or frozen. And Medicare and Medicaid, under this budget that they just adopted, with an inflation rate of under 4 percent, Medicaid is projected to grow at between 16 percent and 11 percent a year, and Medicare at between 11 percent and 9 percent a year. In other words, over the next 5 year period, both will grow at more than 3 times the rate of inflation. What we propose to do is to let them grow at twice the rate of inflation, too. I think we can live with twice the rate of inflation. Yes, I do. Why? Because the rate of reimbursement increases to doctors and hospitals need not go up so fast in Medicare, because we're going to close the gap between Medicare in the private sector and what doctors and hospitals get. And they will actually save money because we're going to dramatically cut their administrative costs. So they will be getting a raise through reduced administrative expenses that they won't have to get through greater outlays of taxpayer money. And we're going to turn right around and invest that money and more into the drug benefit in the long-term care.

I don't know anybody who has really looked at this thing closely who doesn't think we can get it. Now, there may be people who try to stop us from getting it, but if we can't get a Government health care program down to the point where it can run on twice the rate of inflation, we're in deep trouble. I believe we can, and the program explicitly provides that none of the benefits can be cut.

[*Ms. Brown introduced Jo Barbano, national chair of the AARP legislative council, who discussed the rate of inflation on prescription drug prices without health care reform. A participant then asked if the new health care plan would control the rising cost of prescription drugs.*]

The President. Yes. We have sought and received assurances from many of the drug companies that for nonexperimental or non-newly developed drugs, which do—it costs a fortune to develop a new drug and bring it to market.

And we all know they have to be priced at very high levels early on.

The thing that has bothered me is that other countries have cost controls on their drugs, and so we have companies from America selling drugs made in America in other countries with incomes as high as our elderly people have, for prices one-third of what they're charging Americans. It's just not right. So we're trying to work through that. But a number of the drug companies, to be fair to them, have come forward and said, while you're implementing this program, we'll keep our cost increases to inflation. Then, when we get into the program, the drug services, like every other part of it, will be subject to significant pressures to stay within the rate of inflation or pretty close to it. But what the drug companies will get out of this program, they'll win big, because they will have people able to purchase drugs who never were able to do it before.

So what they give up on the rate of increase they will make back in the volume of sales, if you see what I mean. So they're not going to lose on this deal, they're just going to have to stop increasing the same drugs more and stop charging people so much more for the same health care, but they'll be able to increase their volume.

I saw one person being critical of our health care program the other night on one of these C–SPAN forums that I watched. And he said, "Well," he said, "you know in Germany, the President's always talking about Germany, and they only spend 8.8 percent of their income on health care, and we spend 14.5 percent, but they rely so much more on medicine." Yes, they do, as a result of which they don't have to go to the hospital as much.

So the way our system will work, let me just briefly say, is that the drug benefit itself for elderly people will have a $250 deductible and a copay, but no matter how serious the drug needs are, no one can be required to pay more than $1,000 a year. And obviously, income needs will be taken into account. But we will also have the same benefit for people under 65 as for people over 65. To get the drug benefit, the Part B premium will go up modestly, but it will really help to provide that service to people.

I think it's going to make a huge difference in the quality of life to millions of elderly people. And I think it's going to reduce their need for more extensive care by giving them a maintenance schedule with the most modern medicines. And it will be good for the drug company. It will be a good swap for them to let their regular prices go up less but to be able to sell more.

Q. You were asking for information and those 25,000 older Americans that I just visited and were asking me these questions gave me a report to give to you today. Could I give that to your staff?

The President. Absolutely.

Q. Thank you.

[*Ms. Brown introduced Mildred McCauley, member of AARP's national board of directors, who discussed the high cost of care in nursing homes. A participant then asked about funding for prevention and treatment of Alzheimer's disease and coverage for home and community-based long-term care.*]

The President. Yes. Let me first say what was said here is absolutely right. As all of you know who have ever had a family member affected by this, if you're older and you go to a hospital, you can get care covered by your policies or by Medicare. If you go to a nursing home, you basically have to spend yourself into abject poverty to get any benefits. And as a result of that, we've got a lot of folks in this country who are in trouble.

Also, the least expensive and best way to care for people might be in some community-based setting or at home, and there are relatively limited coverages available for long-term care services. And Alzheimer's is a particular example of this because a lot of people want to care for their loved ones at home, or want them to be able to stay at home for as long as possible, but can't get any help in that regard. I'll come back to the research issue in a moment.

The way this program will work, the long-term care program, is that we will permit home and community-based care to be reimbursed just like nursing home care number one. Number two, the programs will not be means-tested. That is, if people have the ability to pay something, they'll be asked to pay, but they won't be cut out of the program because their income is above a certain amount. So that solves the whole Medicare-Medicaid differential issue. Number three, in order to be eligible for Medicaid nursing home care today you have to have—there's a spend down limit of $2,000. You can

only have $2,000 in assets to be eligible for 100 percent coverage under Medicaid. We're going to raise that to $12,000. And people who are in Medicaid funding in nursing homes—funded nursing homes—only get $30 a month in spending money, $30 a month. In 1977, when I entered public life and became an advocate for people in nursing homes, they got $25 a month. You can imagine—so in other words, in effect, people are getting less than half as much per month as they did in 1977. We propose to raise that to $100 which will take it back about to its 1972 levels.

So I think these things will work if we also provide better regulation and some tax preference for private long-term care insurance to supplement whatever people want or get from our Government program. But this long-term care issue is a very big issue. Keep in mind, again, elderly people are the fastest growing group of our population. Most people would prefer not to be in an institutional setting if they can be cared for at home or in a community setting.

And again, I will say to you, this is another example where sometimes we strain at a gnat and swallow a camel. Yes, it will cost more money to start this program, but over the long run, 20 years from now our health care system in the aggregate will be cheaper because we provide a wider range of care options and we don't shove everybody into the most expensive option to get any help at all. So that's how that will work.

Now, on the Alzheimer's question in particular, the way this system of funding works, we are going to develop a stream of funding that will increase our investment in medical research of all kinds, including research in the care and treatment of Alzheimer's. So you'll get more medical research. I will say again, we have been driven here not to mess up what is right with American medicine and American health care, we want to enhance what is right and only focus on what is wrong in trying to deal with it.

Q. Thank you for that response, Mr. President. I'm sure that you recognize that the issue of long-term care is one that is so very, very important to us and that we will be reminding you about it. You can be sure of that.

The President. You don't have to remind me, you've got to remind Congress. Because there will be people who say, well, now, wait a minute. And that's why I really thank the three Members from California who are here today. They're going to have some tough decisions to make. You know, there will be a lot of people who won't want to go through some of these changes that we're recommending, and there will be a lot of people who say, well, let's just play it safe and take the—we know the least expensive course. There will be those who say, let's take these reductions in Medicare and Medicaid increases, these savings from projected increases, and put them into paying for the regular package that the President has proposed, and think about long-term care and medicine some other day.

So we need you guys to show up and be heard in the Capitol to support the Members of Congress who want to see this as a critical element of the ultimate resolution of our health care crisis.

[*Ms. Brown introduced Marie Smith, chair of the economics committee of the national legislative council, who discussed cost containment. A participant then asked about cost containment provisions in the health care plan.*]

The President. Thank you. First of all, as all of you know, we have runaway costs now, both in the system as a whole and for individuals who are paying into it. To keep down individual cost increases as well as systematic cost increases, we seek to do three things that we've factored in. There are a lot of things we are doing, I want to try to emphasize this; we think we'll get more cost containment than we have budgeted for, and I want to explain why.

Number one, if you simplify the system so that essentially every patient, every doctor, every insurer is dealing with a single uniform form, one for each category of people in the system, you will drastically cut the administrative cost of this health care system. We were at the Children's Hospital in Washington the other day; one hospital in one city in America estimates that they spend $2 million a year and enough time for their doctors to see another 10,000 children a year on paperwork that has nothing to do with the care of the kids or keeping up with their records necessary to monitor the care of the kids. That's the first thing.

Number two, if you cover everybody and require everybody to make some contribution to the system, that will stop a lot of the cost shifting. Keep in mind, a lot of your costs keep going up every year more and more and more

because you are paying into the system, either through Medicare or through private insurance, and you pay for everybody else because the hospitals shift their uncompensated care bills to you or to insurance companies who turn around and raise the price or the Government who comes around and raises the price. So through simple administrative simplification and stopping cost shifting, you're going to have some savings.

Number three, as a backup, we also propose a cap, a limit on how much the cost of the system can increase in any given year, moving down towards inflation plus population growth over a period of years. But still, I will tell you, that we still believe—this budget is very modest. We still project over the next 5—between now and the year 2000, the American health care system will go from spending 14.5 percent of our income on health care to about 18 percent, picking up the drugs and the long-term care. If we don't do anything, we'll have no drugs, no long-term care, and be spending over 19 percent of our income on health care.

But those are very modest. Now, that means that we are calculating no savings from putting all the people in the country in these large buyer groups so that they can compete for lower prices. Look what happened to the California public employees plan. Look how little their inflation was this year. The Mayo Clinic managed care plan—most people believe Mayo Clinic provides pretty good health care—you know what their inflation was this year? 3.9 percent, and their prices before they started were lower than the national average.

We don't calculate any of those savings in our budget, the things that will come from better organizing and delivering health care and giving consumer groups the right to bargain to keep their prices lower. We have an initiative to eliminate fraud and abuse, which is significant in this system. We calculate none of those savings into our budget.

So we believe we will easily make the budget because a lot of the things we're going to do that will save money we don't even try to claim credit for to try to bend over backward to be realistic. So I think we'll get there. But you're right, you've got to have cost control.

Let me just say one other thing. There's one other thing we need to help the AARP on. There are a lot of people in the Congress who say that limitations on the rate of increases amount to some sort of price controls, and we shouldn't have them. But look what we've had so far. If you have a third-party pay system, where the people who are working the system can get a check every time they send a bill, there are no normal market forces. You have to have some sort of discipline on the system. Now, I know the AARP favors that. And again, I want you to help us get that when this bill goes to the Congress. We believe we will more than meet the cap that we've set. We don't think we can ever necessarily even meet that cap, but we better have it in the law so people will have to know they're going to have to manage their business better, they can't keep breaking the bank.

Ms. Brown. Well, Mr. President, the time has passed so quickly. I believe it's now time, if you have some closing remarks.

The President. Let me say, first of all, I think when I leave, Mr. Magaziner is going to come up here. Ira Magaziner who has been the sort of leading light of our health care efforts in the First Lady's group on health care and who knows the answers to questions you haven't even thought of yet—at least questions I haven't thought of yet—is going to come up here and spend up to another hour answering any questions you have about the specifics of our plan. So I hope that those of you here who are interested will stay and continue to ask questions. He and some others who have come all the way to California with me, who are working in our health care effort, are going to stay. So we want to encourage all Americans to ask questions and to give us our ideas—their ideas. We don't pretend to have all the answers.

I just want to make two points in closing. Number one, I am not interested in having this become a partisan, political issue. I am profoundly grateful to the distinguished Republican Senator from Vermont, Jim Jeffords, for announcing that he intends to be a cosponsor of our initiative. That's the kind of thing we need more of, working together.

Number two, we've got to keep working on making this better, the evidence of other countries is, but you have to keep working every year. But that's why we've built this in a phased-in fashion, so that the more we learn, the more we can make adjustments and the more we can make improvements.

The point I want to make, the two of you have already made out here in these questions, is if we do nothing, it will be more costly and

less satisfactory than if we take steps. And finally, let me say, we have to overcome the disbelief in America. A lot of folks don't think we can do this, but that's what they said when Social Security came in. People said we couldn't do it, but we did it.

I hold this health security card up all the time, but you just think, if everybody had a Social Security card and a health security card, what a better country this would be and how much better life would be for all the American people.

Thank you very much.

NOTE: The President spoke at 8:50 a.m. at Dr. Paul Carlson Memorial Park.

Statement on the Arts and Humanities Awards Recipients
October 5, 1993

These extraordinary individuals have made a gift to American cultural life that is beyond measure. Through these awards we celebrate their impressive achievements and extend our deepest thanks for efforts that nourish our creative and intellectual spirit.

NOTE: The President's statement was included in a White House statement announcing the awards ceremony for the National Medal of Arts and the Charles Frankel Prize scheduled for October 7.

Named by the President as 1993 National Medal of Arts recipients were:

Walter and Leonore Annenberg, arts patrons, Wynnefield, PA
Cabell "Cab" Calloway, singer and bandleader, White Plains, NY
Ray Charles, singer and musician, Los Angeles, CA
Bess Lomax Hawes, folklorist, Arlington, VA
Stanley Kunitz, poet, editor, and educator, NY, NY/Provincetown, MA
Robert Merrill, baritone, New Rochelle, NY
Arthur Miller, playwright and author, New York, NY
Robert Rauschenberg, artist, Captiva Island, FL
Lloyd Richards, theatrical director, New York, NY
William Styron, author, Vineyard Haven, MA
Paul Taylor, dancer and choreographer, New York, NY
Billy Wilder, movie director, writer, and producer, Hollywood, CA

Winners of the Charles Frankel Prize for their work in the humanities were:

Richard E. Alegria, anthropologist, San Juan, Puerto Rico
John Hope Franklin, historian, Durham, NC
Hanna Holborn Gray, former University of Chicago president, Chicago, IL
Andrew Heiskell, philanthropist, New York, NY
Laurel T. Ulrich, author and historian, Durham, NH

Biographies of the recipients were made available by the Office of the Press Secretary.

Statement by the Press Secretary on the President's Telephone Conversation With President Boris Yeltsin of Russia
October 5, 1993

The President called President Yeltsin today from Air Force One to discuss the situation in Moscow. The two leaders spoke for 20 minutes. The President's purpose in calling was to express the continued, strong support of the United States for President Yeltsin and the Russian Government in the wake of the political crisis in Russia.

President Yeltsin thanked the President for his support during the crisis and described the